FOR OHF USE

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2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0038596

Facility Name: CLARK MANOR CONVALESCENT CENTER, INC.

Address: 7433 N CLARK STREET (Number) CHICAGO (City) 60626 (Zip Code)

County: COOK

Telephone Number: (773) 338-8778 **Fax #** (773) 764-7449

IDPA ID Number: 36-3829755-001

Date of Initial License for Current Owners: 11/01/77

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust	X	Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment

Officer or Administrator of Provider	(Signed)	(Date)
	(Type or Print Name)	
	(Title)	
Paid Preparer	(Signed)	SEE ACCOUNTANT'S REPORT ATTACHED (Date)
	(Print Name and Title)	ARTHUR M. ROTHBLATT, CPA
	(Firm Name & Address)	FROST, RUTTENBERG & ROTHBLATT, P.C. 111 Pfingsten Rd. , Suite 300, Deerfield, Il 60015
	(Telephone)	(847) 236-1111 Fax # (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	273	Skilled (SNF)	273	99,918	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	273	TOTALS	273	99,918	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	21,259	169	1,636	23,064	8
9	SNF/PED					9
10	ICF	66,174	1,855	30	68,059	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	87,433	2,024	1,666	91,123	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 91.20%

D. How many bed-hold days during this year were paid by Public Aid? 956 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 11/01/77

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 33 and days of care provided 1,695

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/00 Fiscal Year: 12/3100

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENT # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage	Supplies	Other	Total	Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	282,924	32,273	21,160	336,357		336,357	(12)	336,345			1
2	Food Purchase		416,800		416,800	(74,884)	341,916	(92)	341,824			2
3	Housekeeping	254,302	60,889		315,191		315,191		315,191			3
4	Laundry	104,405	26,473		130,878		130,878		130,878			4
5	Heat and Other Utilities			182,302	182,302		182,302	(11,846)	170,456			5
6	Maintenance	25,642	17,290	133,814	176,746		176,746	(29,599)	147,147			6
7	Other (specify):*											7
8	**TOTAL General Services**	667,273	553,725	337,276	1,558,274	(74,884)	1,483,390	(41,549)	1,441,841			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400		4,400			9
10	Nursing and Medical Records	2,655,062	133,338	46,441	2,834,841		2,834,841	(938)	2,833,903			10
10a	Therapy	83,407		13,812	97,219		97,219		97,219			10a
11	Activities	120,124	14,367		134,491		134,491		134,491			11
12	Social Services	170,767	4,677	4,826	180,270		180,270		180,270			12
13	Nurse Aide Training											13
14	Program Transportation			209	209		209		209			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	3,029,360	152,382	69,688	3,251,430		3,251,430	(938)	3,250,492			16
	C. General Administration											
17	Administrative	61,507		1,313,632	1,375,139		1,375,139	(516,076)	859,063			17
18	Directors Fees											18
19	Professional Services			128,866	128,866	(371)	128,495	(5,648)	122,847			19
20	Dues, Fees, Subscriptions & Promotions			52,864	52,864		52,864	(22,984)	29,880			20
21	Clerical & General Office Expenses	140,134	38,341	170,092	348,567		348,567	(125,032)	223,535			21
22	Employee Benefits & Payroll Taxes			738,295	738,295	74,884	813,179	(10,766)	802,413			22
23	Inservice Training & Education											23
24	Travel and Seminar			8,245	8,245		8,245	(3,904)	4,341			24
25	Other Admin. Staff Transportation			5,278	5,278		5,278	(3,306)	1,972			25
26	Insurance-Prop.Liab.Malpractice			99,794	99,794		99,794		99,794			26
27	Other (specify):*							20,778	20,778			27
28	**TOTAL General Administration**	201,641	38,341	2,517,066	2,757,048	74,513	2,831,561	(666,938)	2,164,623			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	3,898,274	744,448	2,924,030	7,566,752	(371)	7,566,381	(709,425)	6,856,956			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

CLARK MANOR CONVALESCENT CENTER, INC.
0038596
COST REPORT RECLASSIFICATIONS
01/01/00
12/31/00

SCHEDULE V LINE #			
22	EMPLOYEE BENEFITS	74,884	
2	FOOD		74,884

To reclass cost of employee meals from raw food to employee benefits

33	REAL ESTATE TAX	371	
19	PROFESSIONAL FEES		371

To reclass cost of appealing real estate taxes

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. #0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			180,824	180,824		180,824	18,740	199,564			30
31	Amortization of Pre-Op. & Org.			6,519	6,519		6,519		6,519			31
32	Interest			433,989	433,989		433,989	(60,006)	373,983			32
33	Real Estate Taxes			321,840	321,840	371	322,211	(6,386)	315,825			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			3,837	3,837		3,837		3,837			35
36	Other (specify):*											36
37	**TOTAL Ownership**			947,009	947,009	371	947,380	(47,652)	899,728			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		96,385	57,499	153,884		153,884		153,884			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			149,878	149,878		149,878		149,878			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		96,385	207,377	303,762		303,762		303,762			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	3,898,274	840,833	4,078,416	8,817,523		8,817,523	(757,077)	8,060,446			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	16,239	30		9
10	Interest and Other Investment Income	(60,006)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(92)	2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(4,056)	24		19
20	Contributions	(2,125)	20		20
21	Owner or Key-Man Insurance	(10,766)	22		21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(125,303)	21		24
25	Fund Raising, Advertising and Promotional	(20,488)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax	(1,993)	21		26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(147,613)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (356,203)		$	30

OHF USE ONLY									
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(400,874)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (400,874)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (757,077)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

CLARK MANOR CONVALESCENT CENTER, INC.

ID# 0038596

Report Period Beginning: 01/01/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Deferred Maintenance	$	6	1
2	R&M Capitalized	(28,350)	6	2
3	Apartment Utilities	(11,846)	5	3
4	Apartment R&M	(1,249)	6	4
5	Veteran's Expenses	(741)	10	5
6	Public Relations	(2,100)	21	6
7	Apartment - Fred Davis	(2,400)	21	7
8	Apartment - Real Estate Tax	(5,644)	33	8
9	Jury Duty - CNA	(17)	10	9
10	Real Estate Tax Refund	(742)	33	10
11	Medical Record Fees	(180)	10	11
12	Dietary Rebate	(12)	1	12
13	Out of period Legal Fees	(5,681)	19	13
14	Political Contributions - COPE	(428)	20	14
15	2000 seminar paid for in 1999	150	24	15
16	Deferred State Income Tax - Prior Period	541	21	16
17	Non-Allowable auto expense	(3,306)	25	17
18	Carepath fees	3,000	17	18
19	p/y equip deprec.	2,501	30	19
20	Phone commissions	(94)	21	20
21	Theft loss	(87)	21	21
22	non-allowable management fees	(13,432)	17	22
23	non-allowable allocated salary	(72,000)	17	23
24	non-allowable payroll taxes related to salary	(5,496)	27	24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
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82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	Total	(147,613)		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	(12)											(12)	1
2	Food Purchase	(92)											(92)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities	(11,846)											(11,846)	5
6	Maintenance	(29,599)											(29,599)	6
7	Other (specify):*													7
8	**TOTAL General Services**	(41,549)											(41,549)	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(938)											(938)	10
10a	Therapy													10a
11	Activities													11
12	Social Services													12
13	Nurse Aide Training													13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(938)											(938)	16
	C. General Administration													
17	Administrative	(82,432)		(1,644)	(72,000)	(180,000)	(180,000)						(516,076)	17
18	Directors Fees													18
19	Professional Services	(5,681)		33									(5,648)	19
20	Fees, Subscriptions & Promotions	(23,041)		57									(22,984)	20
21	Clerical & General Office Expenses	(131,436)		404	6,000								(125,032)	21
22	Employee Benefits & Payroll Taxes	(10,766)											(10,766)	22
23	Inservice Training & Education													23
24	Travel and Seminar	(3,906)		2									(3,904)	24
25	Other Admin. Staff Transportation	(3,306)											(3,306)	25
26	Insurance-Prop.Liab.Malpractice													26
27	Other (specify):*	(5,496)		236	26,038								20,778	27
28	**TOTAL General Administration**	(266,064)		(912)	(39,962)	(180,000)	(180,000)						(666,938)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(308,551)		(912)	(39,962)	(180,000)	(180,000)						(709,425)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	TOTALS (to Sch V, col.7)	
30	Depreciation	18,740											18,740	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(60,006)											(60,006)	32
33	Real Estate Taxes	(6,386)											(6,386)	33
34	Rent-Facility & Grounds													34
35	Rent-Equipment & Vehicles													35
36	Other (specify):*													36
37	**TOTAL Ownership**	(47,652)											(47,652)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers													39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	**TOTAL Special Cost Centers**													44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(356,203)		(912)	(39,962)	(180,000)	(180,000)						(757,077)	45

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		NONE		J.S. AFFILIATES	CHICAGO	Mgmt Company
				Shaymark Mgmt	Lincolnwood	Mgmt Company
				JLR Mgmt	Lincolnwood	Mgmt Company
				Carepath	Lincolnwood	Mgmt Company

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	ADMINISTRATIVE	$	Carepath	100.00%	$ 1,356	$ 1,356	15
16	V	19	PROFESSIONAL FEES		Carepath		33	33	16
17	V	20	FEES, SUBSCRIPTIONS		Carepath		57	57	17
18	V	21	CLERICAL AND GENERAL		Carepath		404	404	18
19	V	24	SEMINARS		Carepath		2	2	19
20	V	27	GEN ADMIN.- EMP. BEN.		Carepath		236	236	20
21	V								21
22	V								22
23	V								23
24	V	17	MANAGEMENT FEES	3,000	Carepath		0	(3,000)	24
25	V	0					0		25
26	V	0					0		26
27	V	0					0		27
28	V	0					0		28
29	V	0					0		29
30	V	0					0		30
31	V	0					0		31
32	V	0					0		32
33	V	0					0		33
34	V	0							34
35	V	0		0					35
36	V								36
37	V								37
38	V								38
39	Total			$ 3,000			$ 2,088	$ * (912)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	331,200	J.S. AFFILIATES			$ (331,200)	15
16	V	17	ADMINISTRATIVE FEES	220,800	J.S. AFFILIATES			(220,800)	16
17	V	17	ADMINISTRATIVE SALARY		J.S. AFFILIATES		480,000	480,000	17
18	V	27	PAYROLL TAXES		J.S. AFFILIATES		26,038	26,038	18
19	V	21	TELEPHONE		J.S. AFFILIATES		6,000	6,000	19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 552,000			$ 512,038	$ * (39,962)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	180,000	SHAYMARK			$ (180,000)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 180,000			$ 0	$ * (180,000)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	17	MANAGEMENT FEES	$ 180,000	JLR MANAGEMENT		$	$ (180,000)	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 180,000			$ 0	$ * (180,000)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number CLARK MANOR CONVALESCENT CEN # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	JACK SCHNELL	Executive Director	Administrative	9.11%	None	40	100.00%	Alloc. Salary	$ 120,000	17-7	1
2	JACK SCHNELL	Executive Director	Administrative					Admin. Fees	120,000	17-3	2
3	DAVID SCHNELL	Manager	Administrative	1.72%	None	40	100.00%	Alloc. Salary	156,000	17-7	3
4	DAVID SCHNELL	Manager	Administrative					Admin. Fees	120,000	17-3	4
5	MORRIS SCHABES	Manager	Administrative	1.10%	None	40	100.00%	Alloc. Salary	132,000	17-7	5
6	MORRIS SCHABES	Manager	Administrative					Admin. Fees	120,000	17-3	6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 768,000		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees) FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: CAREPATH HEALTH NETWORK
Street Address: 6633 N LINCOLN AVENUE
City / State / Zip Code: LINCOLNWOOD, IL 60712
Phone Number: (888) 707-6700
Fax Number: (847) 679-2150

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	17	ADMINISTRATIVE	CARE PATH FEES	608,174	14	$ 274,940	$ 273,771	3,000	$ 1,356	1
2	19	PROFESSIONAL FEES	CARE PATH FEES	608,174	14	6,646		3,000	33	2
3	20	FEES, SUBSCRIPTIONS	CARE PATH FEES	608,174	14	11,535		3,000	57	3
4	21	CLERICAL AND GENERAL	CARE PATH FEES	608,174	14	81,974	63,989	3,000	404	4
5	24	SEMINARS	CARE PATH FEES	608,174	14	449		3,000	2	5
6	27	GEN ADMIN.- EMP. BEN.	CARE PATH FEES	608,174	14	47,810		3,000	236	6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 423,354	$ 337,760		$ 2,088	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number CLARK MANOR CONVALESCENT CENT # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Mid-North Financing Serv		X	Mortgage	$49,082.17	12/18/89	$ 5,000,000	$ 3,471,097	12/18/09	10.0000	$ 366,477	1
2	1st Bank & Trust of Evanston		X	Auto Loan	$944.30	11/10/98	38,590	21,242	10/10/02	7.9500	1,992	2
3												3
4												4
5												5
	Working Capital											
6	Shareholder's Loan	X		Working Capital			1,092,000	1,092,000			65,520	6
7												7
8												8
9	TOTAL Facility Related				$50,026.47		$ 6,130,590	$ 4,584,339			$ 433,989	9
	B. Non-Facility Related*											
10	Supplemental Schedule										(60,006)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (60,006)	14
15	TOTALS (line 9+line14)						$ 6,130,590	$ 4,584,339			$ 373,983	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTEI # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	Interest Income		X				$	$			$ (60,006)	1
2												2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (60,006)	21

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	339,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	321,196	2
3. Under or (over) accrual (line 2 minus line 1).	$	(17,804)	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	334,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	371	5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ 1,114 For 19 94&93 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	(742)	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6	$	315,825	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	326,105	8
	1996	334,128	9
	1997	332,279	10
	1998	329,048	11
	1999	326,840	12

1999 tax includes apartment building real estate tax: $5,644, adjusted out on page 5

Accrual = 1999 tax X 1.02

326,840 X 1.02 = 333,377 (rounded)

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 49,255 B. General Construction Type: Exterior _____ Frame _____ Number of Stories 5

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Apartment building: All expenses have been adjusted out on page 5
All costs are in the non-care section on page 13

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 130,336
2. Number of Years Over Which it is Being Amortized: 20
3. Current Period Amortization: 6,519
4. Dates Incurred: 1990

Nature of Costs: Loan costs
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Facility		1977	$ 220,000	1
2					2
3	TOTALS			$ 220,000	3

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	273		1977	1973	$ 3,129,625	$ 104,321	35	$ 104,321	$	$ 1,790,842	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1993	15,908		20	795	795	5,565	9
10	Various			1994	41,939		20	2,095	2,095	13,248	10
11	Various			1995	18,032		20	902	902	5,230	11
12	2 GARBAGE DISPOSALS			1996	2,785		20	139	139	602	12
13	COMPRESSOR			1996	1,157		20	58	58	261	13
14	WINDOW BLINDS			1996	2,195		20	110	110	504	14
15	WINDOW TREATMENTS			1996	1,025		20	51	51	234	15
16	MINI BLINDS			1996	1,121		20	56	56	280	16
17	CUBICLE CURTAINS			1996	4,930		20	247	247	1,132	17
18	EMERGENCY GENER.			1997	31,441	3,928	20	1,572	(2,356)	5,633	18
19	GENERATOR			1997	16,450	2,055	20	823	(1,232)	2,949	19
20	COPPER PIPE			1997	2,873		20	144	144	444	20
21	PUMP			1997	2,460	284	20	123	(161)	472	21
22	GENERATOR			1997	9,499	1,187	20	475	(712)	1,821	22
23	BOILER			1997	12,800	1,474	20	640	(834)	2,400	23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31	PAGE 12E TOTALS				109,948	2,751		5,498	2,747	22,646	31
32	PAGE 12D TOTALS				312,834	7,292		13,144	5,852	103,845	32
33	PAGE 12C TOTALS				210,496	3,831		11,448	7,617	63,816	33
34	PAGE 12B TOTALS				42,473	770		2,073	1,303	3,217	34
35	PAGE 12A TOTALS				64,238	4,110		3,215	(895)	10,577	35
36	TOTAL (lines 4 thru 35)				$ 4,034,229	$ 132,003		$ 147,929	$ 15,926	$ 2,035,718	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	GENERATOR			1997	16,450	2,055	20	823	(1,232)	3,018	9
10	EXI SYSTEM			1997	4,959		20	248	248	930	10
11	PUMP HOUSING			1997	1,870		20	94	94	321	11
12	BEARING ASSEMBLY			1997	892		20	45	45	158	12
13	VERTICLE BLINDS			1997	1,088		20	54	54	189	13
14	INSULATION			1997	2,486		20	124	124	455	14
15	33 SIGNS/BASEMENT			1997	1,958		20	98	98	343	15
16	GENERATOR			1997	16,450	2,055	20	823	(1,232)	2,881	16
17	REMOTE TEMP CONTROL			1998	515		20	26	26	59	17
18	WATER PUMP			1998	665		20	33	33	96	18
19	DESCALING ACID			1998	2,140		20	107	107	303	19
20	WASHER MOTOR			1998	662		20	33	33	72	20
21	REMOTE TEMP CONTROL			1998	513		20	26	26	54	21
22	A/C ELIMINATOR UNIT			1998	1,460		20	73	73	201	22
23	BLOWER MOTORS			1998	912		20	46	46	100	23
24	KU SYSTEM			1998	625		20	31	31	93	24
25	BEARING ASSY			1998	1,080		20	54	54	113	25
26	BOILER GAS VALVE			1998	1,377		20	69	69	155	26
27	CALL LIGHTS			1998	519		20	26	26	76	27
28	FIRE DETECTOR			1998	520		20	26	26	76	28
29	SPEED REDUCER			1998	640		20	32	32	85	29
30	PREWASH MOTOR			1998	555		20	28	28	72	30
31	2 RELAY CONTROLS			1998	2,257		20	113	113	292	31
32	BEARING ASSY & PUMP			1998	690		20	35	35	88	32
33	THERMOSTAT CONTROLS			1998	1,634		20	82	82	198	33
34	BOILER MAIN GUAGE			1998	784		20	39	39	111	34
35	2 MOTORS & SWITCHES			1999	537		20	27	27	38	35
36	TOTAL (lines 4 thru 35)				$ 64,238	$ 4,110		$ 3,215	$ (895)	$ 10,577	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	BEARING ASSEMBLY			1999	925		20	46	46	77	9
10	PATIO DECK			1999	2,669		20	133	133	177	10
11	GLOBEL RECONDITIONED			1999	979	49	20	49		90	11
12	VALVE & ASSEMBLY			1999	2,402		20	120	120	190	12
13	FAN COIL & INGNITER			1999	865		20	43	43	82	13
14	COMPRESSOR			1999	9,132	457	20	457		762	14
15	WINDOWS			1999	669		20	33	33	61	15
16	REPAIR ROOF			1999	1,875		20	94	94	188	16
17	COMPRESSOR			1999	1,015		20	51	51	102	17
18	BEARING ASSEMBLY			1999	771		20	39	39	75	18
19	TRANSFORMER			1999	1,350	68	20	68		113	19
20	SMOKE DET. CAMERA			1999	1,150	58	20	58		102	20
21	BOOOSTER HEATER			1999	2,393	120	20	120		240	21
22	2 MOTORS & U BELTS			1999	854		20	43	43	75	22
23	BEARING ASSEMBLY			1999	1,335		20	67	67	84	23
24	3 VALVES			1999	2,715		20	136	136	159	24
25	INSTALL DOOR MGNETS			1999	1,129		20	56	56	84	25
26	SHEET METAL CONNECTO			1999	665		20	33	33	58	26
27	PUMP BEARING ASSEM.			1999	810		20	41	41	48	27
28	PIPE & SHEET METAL			1999	2,660		20	133	133	166	28
29	MOTOR & BEARING ASSY			1999	765		20	38	38	41	29
30	HOT GAS DEFROST VALV			1999	785		20	39	39	42	30
31	2 DUAL DRIVE MOTOR			1999	1,188		20	59	59	64	31
32	PUMP MOTOR			1999	750		20	38	38	44	32
33	SMOKE DET. CAMERA			1999	350	18	20	18		32	33
34	MOTOR & FAN PULLEYS			2000	872		20	35	35	35	34
35	WATER HEATER VALVE			2000	1,400		20	26	26	26	35
36	TOTAL (lines 4 thru 35)				$ 42,473	$ 770		$ 2,073	$ 1,303	$ 3,217	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	PUMP			2000	1,846	369	20	369		369	9
10	INTERCOM			2000	1,142	163	20	163		163	10
11	WALK-IN COOLER			2000	7,000	1,400	20	1,400		1,400	11
12	3 FLANGED LUBE COCKS			2000	3,785		20	103	103	103	12
13	HEATER VALVE			2000	1,865		20	12	12	12	13
14	THERMOSTAT			2000	541		20	8	8	8	14
15	MOTOR			2000	1,074		20	20	20	20	15
16	STARTER & HEATER			2000	524		20	23	23	23	16
17	GAS GENERATOR & FANS			2000	640		20	15	15	15	17
18	MOTOR & FAN			2000	640		20	25	25	25	18
19	SECURITY DOOR PARTS			2000	1,855		20	81	81	81	19
20	KITCHEN FAN MOTOR			2000	3,358		20	133	133	133	20
21	MOTORS & MOUNTS			2000	1,264		20	34	34	34	21
22	ROOM FAN COIL PARTS			2000	885		20	24	24	24	22
23	VALVES			2000	2,745		20	97	97	97	23
24	TEMPERATURE CONTROLLER			2000	935		20	33	33	33	24
25	FAN COIL MOTORS			2000	828		20	22	22	22	25
26	BEARING ASSEMBLY			2000	1,709		20	11	11	11	26
27	MOTOR & REVERSER			2000	770		20	21	21	21	27
28											28
29	VARIOUS			1995	42,375	1,087	20	2,118	1,031	11,494	29
30	VARIOUS			1992	70,740	127	20	3,538	3,411	24,766	30
31	VARIOUS			1991	2,950		20	147	147	1,029	31
32	VARIOUS			1990	18,810	398	20	940	542	6,580	32
33	VARIOUS			1989	16,022	167	20	801	634	5,607	33
34	VARIOUS			1988	14,754	120	20	738	618	5,166	34
35	VARIOUS			1987	11,439		20	572	572	6,580	35
36	TOTAL (lines 4 thru 35)				$ 210,496	$ 3,831		$ 11,448	$ 7,617	$ 63,816	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1986	40,628	2,017	20	2,031	14	17,203	9
10	VARIOUS			1985	25,843	1,158	20	1,292	134	11,628	10
11	VARIOUS			1984	35,709		20	1,785	1,785	20,827	11
12	VARIOUS			1977	50,000		20			33,889	12
13	SHEET METAL WORK			1999	5,533	142	20	277	135	508	13
14	ROOF MAINTENANCE			1999	2,450	63	20	123	60	164	14
15	SMOKE ALARM SYSTEM			1999	5,251	135	20	263	128	395	15
16	AIR-CONDITIONING			1999	12,989	333	20	649	316	919	16
17	LOBBY IMPROVEMENT			1998	10,000	256	20	500	244	1,417	17
18	AIR CONDITIONING			1998	58,500	1,500	20	2,925	1,425	8,044	18
19	LOBBY IMPROVEMENT			1998	5,000	128	20	250	122	667	19
20	GENERAL IMPROVEMENTS			1998	1,500	38	20	75	37	194	20
21	LOBBY IMPROVEMENT			1998	2,050	53	20	103	50	258	21
22	IRON WORK			1998	2,975	76	20	149	73	373	22
23	SECURITY SYSTEM			1998	6,250	160	20	313	153	783	23
24	LOBBY IMPROVEMENT			1998	3,473	89	20	174	85	378	24
25	IRON WORK			1998	2,975	76	20	149	73	360	25
26	SECURITY SYSTEM			1998	8,200	210	20	410	200	957	26
27	FIRE DAMPERS			1998	8,472	217	20	424	207	893	27
28	SECURITY SYSTEM			1998	6,284	161	20	314	153	702	28
29	REAR ENTRY DOOR			1997	2,155	55	20	108	53	423	29
30	CEILING LIGHT COVERS			1997	937	24	20	47	23	180	30
31	FENCING			1997	1,848	47	20	92	45	322	31
32	DINING ROOM IMP			1997	1,826	47	20	91	44	319	32
33	BACK HALLWAY IMP			1997	1,561	40	20	78	38	273	33
34	WINDOWS			1997	6,950	178	20	348	170	1,189	34
35	WINDOWS			1997	3,475	89	20	174	85	580	35
36	TOTAL (lines 4 thru 35)				$ 312,834	$ 7,292		$ 13,144	$ 5,852	$ 103,845	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	LOCK SYSTEM			1997	2,500	64	20	125	61	417	9
10	ELECTRICAL WORK			1997	6,320	162	20	316	154	1,053	10
11	HVAC			1997	7,280	187	20	364	177	1,183	11
12	ARCHITECTURE			1997	2,560	66	20	128	62	405	12
13	TUCKPOINTING			1997	2,050	53	20	103	50	318	13
14	ARCHITECTURE			1997	2,560	66	20	128	62	395	14
15	WALL COVERING			1996	3,824	98	20	191	93	955	15
16	HAND RAILS			1996	9,210	236	20	461	225	2,305	16
17	WALL COVERING			1996	10,000	256	20	500	244	2,500	17
18	WALL COVERING			1996	10,149	260	20	507	247	2,450	18
19	WALL COVERING			1996	10,000	256	20	500	244	2,292	19
20	2ND FLOOR CORRIDOR			1996	1,800	46	20	90	44	405	20
21	3RD FLOOR CORRIDOR			1996	3,675	94	20	184	90	828	21
22	ROOFING			1996	2,900	74	20	145	71	653	22
23	ROOFING			1996	5,080	130	20	254	124	1,122	23
24	4TH FLOOR CORRIDOR			1996	9,999	256	20	500	244	2,125	24
25	DINING ROOM			1996	2,100	54	20	105	51	437	25
26	CEILING TILES			1996	699	18	20	35	17	146	26
27	BASEMENT CORRIDOR			1996	6,730	173	20	337	164	1,376	27
28	PUMP			1999	8,245		20	412	412	790	28
29	BOLIER			1996	2,267	202	20	113	(89)	491	29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 109,948	$ 2,751		$ 5,498	$ 2,747	$ 22,646	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
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27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9											9
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28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$	$		$	$	$	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 556,284	$ 38,652	$ 45,069	$ 6,417		$ 277,941	37
38	Current Year Purchases	28,389	4,766	3,617	(1,149)		3,617	38
39	Fully Depreciated Assets	318,820	4,955		(4,955)		318,820	39
40								40
41	TOTALS	$ 903,493	$ 48,373	$ 48,686	$ 313		$ 600,378	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42	Facility Business	1998 Cadillac	1998	$ 45,590	$ 2,950	$ 2,950	$	3	$ 10,230	42
43										43
44										44
45										45
46	TOTALS			$ 45,590	$ 2,950	$ 2,950	$		$ 10,230	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 5,203,312	47	
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 183,326	48	
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 199,565	49	**
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ 16,239	50	
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 2,646,326	51	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	Apartment Building	$ 30,000	$ 0	$ 30,000	52
53	Apartment Land	30,000	0	0	53
54					54
55					55
56					56
57	TOTALS	$ 60,000	$	$ 30,000	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

CLARK MANOR CONVALESCENT CENTER, INC.
0038596
RELATED COMPANY MOVABLE EQUIPMENT SCHEDULE
12/31/00

COMPANY NAME	COST	CURRENT BOOK (FED) DEPRECIATION	STRAIGHT LINE DEPRECIATION	ADJUSTMENTS	ACCUMULATED S/L DEPRECIATION
LINE 28: PRIOR YEARS					
Clark Manor Inc.	444,017	38,495	43,129	4,634	216,275
Clark Manor Associates	112,267	157	1,940	1,783	61,666
TOTALS	556,284	38,652	45,069	6,417	277,941
LINE 29: CURRENT YEAR					
Clark Manor Inc.	28,389	4,766	3,617	(1,149)	3,617
Clark Manor Associates					
TOTALS	28,389	4,766	3,617	(1,149)	3,617
LINE 30: FULLY DEPRECIATED					
Clark Manor Inc.	30,769	4,955		(4,955)	30,769
Clark Manor Associates	288,051				288,051
TOTALS	318,820	4,955		(4,955)	318,820
TOTALS (Should Tie to Totals on Page 13)					
Clark Manor Inc.	503,175	48,216	46,746	(1,470)	250,661
Clark Manor Associates	400,318	157	1,940	1,783	349,717
TOTALS	903,493	48,373	48,686	313	600,378

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [ ] NO

16. Rental Amount for movable equipment: $ 3,837 Description: see attached
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$ 0	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   [ ] YES
   [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-3	hrs	$		$ 4,951	$		$ 4,951	1
2	Licensed Speech and Language Development Therapist	39-3	hrs			5,213			5,213	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-3	hrs			47,335			47,335	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				58,586		58,586	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): **SEE SUPPLEMENTAL SCHEDULE**						37,799		37,799	13
14	TOTAL			$		$ 57,499	$ 96,385		$ 153,884	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

SUPPLEMENTAL SCHEDULE OF MEDICAL SUPPLIES

	Special Services - Supplies (Column 6 - Other)	Amount
1	Medical Supplies	
2	Complex Medical Equip	
3	Oxygen	
4	Equipment Rental	36,122
5	Laboratory	1,442
6	X-Ray	235
7		
8		
9		
10		
		37,799

	Outside Therapies (Column 5 - Other)	Amount
1	Respiratory Therapy	
2		
3		
4		
5		
6		
7		
8		
9		
10		

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 12/31/00 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 648,339	$	1
2	Cash-Patient Deposits	77,798		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	1,603,825		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	364		6
7	Other Prepaid Expenses	2,331		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify): See supplemental schedule	192,863		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,525,520	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	220,000		13
14	Buildings, at Historical Cost	3,129,625		14
15	Leasehold Improvements, at Historical Cos	480,909		15
16	Equipment, at Historical Cost	1,283,404		16
17	Accumulated Depreciation (book methods)	(3,714,534)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	130,336		19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(71,672)		20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	118,664		22
23	Other(specify): See supplemental schedule			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,576,732	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 4,102,252	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 151,330	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	136,462		28
29	Short-Term Notes Payable	254,441		29
30	Accrued Salaries Payable	78,422		30
31	Accrued Taxes Payable (excluding real estate taxes)	(184)		31
32	Accrued Real Estate Taxes(Sch.IX-B)	334,000		32
33	Accrued Interest Payable	29,660		33
34	Deferred Compensation			34
35	Federal and State Income Taxes	18,429		35
	Other Current Liabilities(specify):			
36	See supplemental schedule	15,333		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 1,017,893	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,329,898		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 4,329,898	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 5,347,791	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (1,245,539)	$ #REF!	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 4,102,252	$ #REF!	48

*(See instructions.)

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF OTHER ASSETS & LIABILITIES **As of** 12/31/00

OTHER CURRENT ASSETS:	Amount	Amount
Real Estate Tax Escrow	190,430	
Employee Advances	2,433	
	192,863	

OTHER CURRENT LIABILITIES:	Amount	Amount
Accrued Expenses	158	
Accrued R. E. Tax - Non Care Property		
Security Deposits	1,650	
Wage Assignments	2,802	
Due to Medicare/Public Aid	10,723	
	15,333	

OTHER NON CURRENT ASSETS:

Construction In Progress
Utility Deposit
Loan Costs

OTHER NON CURRENT LIABILITIES:

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (1,261,302)	1
2	Restatements (describe):		2
3	Schedule attached		3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (1,261,302)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	435,609	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	(419,846)	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 15,763	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (1,245,539)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number	CLARK MANOR CONVALESCENT C#	0038596	Report Period Beginning:	01/01/00	Ending:	12/31/00

Balance per General Ledger		(1,261,302)
Adjustments:		
		-
		-
		-
Total adjustments		-
Balance - Beginning of Year		(1,261,302)
Equity(Deficit) from Page 17 Col 1		(1,245,539)
Related Party		
Equity(Deficit)	0	
Income	0	
		-
Combined Equity - End of Year		(1,245,539)

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, I # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 8,850,261	1
2	Discounts and Allowances for all Levels	(125,802)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 8,724,459	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	179,083	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 179,083	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	39,449	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	3,643	19
20	Radiology and X-Ray	1,103	20
21	Other Medical Services	203,772	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22**	$ 247,967	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	60,006	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 60,006	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	41,617	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 41,617	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 9,253,132	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,558,274	31
32	Health Care	3,251,430	32
33	General Administration	2,757,048	33
	B. Capital Expense		
34	Ownership	947,009	34
	C. Ancillary Expense		
35	Special Cost Centers	153,884	35
36	Provider Participation Fee	149,878	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 8,817,523	40
41	**Income before Income Taxes (line 30 minus line 40)****	435,609	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 435,609	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? cash basis If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number CLARK MANOR CONVALESCEN' # 0038596 **Report Period Beginning:** 01/01/00 **Ending:** 12/31/00

SUPPLEMENTAL SCHEDULE OF REVENUES
12/31/00

	DESCRIPTION	AMOUNT
1	Vending Commissions	
2	Rent Income	40,200
3	Phone Commissions (adj. out on page 5)	94
4	Medical Record Copies (adj. out on page 5)	180
5	Dietary Rebate (adj. out on page 5)	12
6	Real Estate Tax Rebates	1,114
7	Jury Duty - CNA (adj. out on page 5)	17
8		
9		
10		
11		
12		
13		
14		
15		
16		
17		
18		
19		
20		
	TOTALS	41,617

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,920	2,198	$ 85,065	$ 38.70	1
2	Assistant Director of Nursing	2,009	2,201	58,682	26.66	2
3	Registered Nurses	36,140	39,106	947,053	24.22	3
4	Licensed Practical Nurses	15,600	16,547	270,985	16.38	4
5	Nurse Aides & Orderlies	151,492	170,336	1,259,696	7.40	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	7,089	8,383	83,407	9.95	8
9	Activity Director	895	968	13,154	13.59	9
10	Activity Assistants	14,740	15,923	106,970	6.72	10
11	Social Service Workers	13,940	15,059	170,767	11.34	11
12	Dietician					12
13	Food Service Supervisor	2,080	2,240	32,776	14.63	13
14	Head Cook	6,120	6,902	58,946	8.54	14
15	Cook Helpers/Assistants	22,903	25,007	191,202	7.65	15
16	Dishwashers					16
17	Maintenance Workers	2,080	2,160	25,642	11.87	17
18	Housekeepers	29,583	32,584	254,302	7.80	18
19	Laundry	11,952	13,388	104,405	7.80	19
20	Administrator	2,080	2,133	61,507	28.84	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,806	9,274	140,134	15.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	3,023	3,191	33,581	10.52	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	332,452	367,600	$ 3,898,274 *	$ 10.60	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	463	$ 17,602	1-3	35
36	Medical Director	monthly	4,400	9-3	36
37	Medical Records Consultant	monthly	4,032	10-3	37
38	Nurse Consultant	monthly	17,531	10-3	38
39	Pharmacist Consultant	monthly	4,650	10-3	39
40	Physical Therapy Consultant	285	11,412	10A-3	40
41	Occupational Therapy Consultant	42	1,668	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	138	4,826	12-3	45
46	Other(specify) Kosher Supervision		3,558	1-3	46
47	Language Rehab Program	18	732	10A-3	47
48					48
49	TOTAL (lines 35 - 48)	946	$ 70,411		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	360	$ 3,864	10-3	50
51	Licensed Practical Nurses	235	2,992	10-3	51
52	Nurse Aides	1,370	13,373	10-3	52
53	TOTAL (lines 50 - 52)	1,965	$ 20,229		53

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

SUPPLEMENTAL SCHEDULE OF STAFFING AND SALARY COSTS

B. CONSULTANT SERVICES

# of Hrs. Actually Worked	# of Hrs. Paid and Accrued	Reporting Period Total Salaries, Wages	Average Hourly Wage
		$	$
0	0	$ 0	$ #DIV/0!

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, I # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Mark Schlichting	Administrator	0%	$ 61,507
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 61,507

B. Administrative - Other

Description	Amount
	$
Management Fees - See Attached	719,400
Administrative Fees - See Attached	594,232
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,313,632
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Winston & Strawn	Legal	$ 19,692
Allen Lefkovitz	Legal	152
Katz, Randalll, Weinberg & Richmor	Legal	220
Gomberg, Sharfman, Gold & Strawn	Legal	3,286
Frost, Ruttenberg & Rothblatt	Accounting	74,650
Computer Services - see attached		15,752
Personnel Planners	Unemployment Consultant	1,750
Econocare	Purchasing Agent	4,378
Ray Dolan	JCAHO Consultant	1,000
Landmark Engineering	Site Survey	3,800
TransAmerica	401K Administration	4,187
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 128,867

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 41,108
Unemployment Compensation Insurance	19,097
FICA Taxes	291,871
Employee Health Insurance	332,923
Employee Meals	74,884
Illinois Municipal Retirement Fund (IMRF)*	
Chicago Head Tax	6,448
Employee Benefits	5,162
Employee Retirement Plan	26,727
Christmas Expense	4,189
TOTAL (agree to Schedule V, line 22, col.8)	$ 802,409

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	6,766
Health Care Worker Background Check	910
(Indicate # of checks performed 91)	
Licenses & Inspections	11,504
Franchise Fee	50
Dues & Subscriptions	10,193
Allocation - Care Path	57
Advertising & Promotion	20,487
Public Relations	2,100
Less: Public Relations Expense	(2,100)
Non-allowable advertising	(20,487)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 29,880

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	4,340
Allocation - Care Path	2
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 4,342

**See instructions.

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1	Painting & Decorating	2/95	$ 2,100	3	$ 700	$ 59	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$ 2,100		$ 700	$ 59	$	$	$	$	$	$	$

Facility Name & ID Number CLARK MANOR CONVALESCENT CENTER, INC. # 0038596 Report Period Beginning: 01/01/00 Ending: 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **yes**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **IL Council on LTC - $9,179**

(3) Did the nursing home make political contributions or payments to a politica action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **10 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,590** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions fo Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmen of Public Aid during this cost report period. $ **149,877**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classifiec in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services fo the patient census listed on page 2, Section B? **no** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions

(15) Indicate the cost of employee meals that has been reclassified to employee benefit on Schedule V. $ **74,884** Has any meal income been offset against related costs? **no** Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation fo residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%ln14**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all othe times when not in use? **no**
f. Has the cost for commuting or other personal use of autos been adjustec out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **no**
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted ou out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of service performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

Date: **07/17/2000**

To: **Administrator/Cost Report Preparer**

From: **Office of Health Finance**

Re: 2000 Long Term Care Cost Report and Instructions on Diskette
Information Regarding the Lotus 5.0 and Excel 97 Versions of the Cost Report

Enclosed you will find a copy of the 2000 cost report and instructions on diskette. For 1999, the majority of nursing homes used the diskette to prepare their cost report. We would appreciate it if you could complete your 2000 cost report using this diskette.

If you choose not to use the diskette, you may print the 2000 cost report form and manually complete the report. If you do not have the ability to print the cost report form and instructions, please contact our office at 217/782-1630 to request a paper copy to be mailed to you.

As is stated on page 1 of the cost report instructions, this report should cover the facility's fiscal year ending in 2000. It is due on September 30, 2000, or ninety days after the close of the facility's fiscal year, **whichever comes later**. Please refer to the instructions for the remainder of the filing requirements.

There are two 2000 cost report files on the disk you have received. One file has been created for use with Lotus 5.0 for Windows. The other file has been created for use with Excel 97. A copy of the 2000 cost report instructions has been included on the diskette also. The name of the file is Instr00. It has been created for use with Word Perfect 6.1. Please use this 2000 diskette. **Printed copies of the report from the 1999 cost report diskette or earlier diskettes will NOT be accepted.**

Each page is on a separate worksheet. The file has been sealed. The cells where data is to b entered have been unprotected. Do not change the cost report form. We must have every form the same. Any changes made to the cost report form will cause us to consider the filed cost report incomplete until the form is correctly filed. Complete page one first. The facility name, IDPH ID# and the report period dates have been linked to each page. (Be sure to enter the IDPH licensed name of the facility.) **When entering data on pages 3 and 4, do not include decimals. Please round to whole numbers. When entering the years on page 12 do not enter various or other text in columns 2 or 3.**

Print macros have been written that will print each individual page or the entire report.

WARNING: Do NOT use drag & drop, cut or move commands. These commands may ruin the file and/or formulas. Then you will have to close the file and start from the last time you saved it.

As you know, save your work frequently to prevent losses of large amounts of information.

The cost report must be printed on 8 ½ by 14 size white paper with an 8 ½ by 14 image on the paper. To ensure an 8 ½ by 14 size image, check the paper size in the Printer Setup. When printing the cost report, be sure the "Selected Range" is checked. If "Current Worksheet" or "A Worksheets" are selected, the printed report will be smaller than it should be. These three selections appear in the Print dialog box. **Please do not reduce the image to 8 ½ by 11. We cannot accept a report with an 8 ½ by 11 image.** After printing the cost report, please review the copy for accuracy and completeness before mailing it to The Office of Health Finance. **Please send in the completed diskette with your paper copy, (being sure to make a copy of the diskette for your records).** Also, please make sure both the completed diskette and the paper copy agree prior to sending to our office.

Notes Applicable only to Lotus users

The entire cost report is in one file named Report00.wk4. A print preview button has been added to the bottom of each page. You may want to preview each page to ensure there are no problems before you print the entire cost report. To preview a page, click this button, then click File-Preview as normal. Also, macros have been written that will allow you to change the column width or row height of a cell or range of cells. **Only use these commands on the extra pages (24 through 33).** The print menu or the other macros menu will appear on the menu ba after you click the macro button. A macro that allows you to "Freeze Both Titles" has been added also. This will be helpful for data entry. **When saving the file in Lotus, please save it as a "WK4" file type instead of a "123" file type. To do this, click File-Save As, and then ensure the file type is "WK4".**

To copy worksheets that you have created into the blank pages at the end of the report, use Fi Combine. This will bring in the styles you used in your worksheet (except for the column width and the row height). This does not work if you are using Lotus 97. Extra sheets for pages 6, 8 and 12 have been included in the file. Click the macro buttons on these pages to make them available.

Notes Applicable only to Excel users

The entire cost report is in one file named Report00.xls. In an Excel 97 file that has been seale you can press the Tab key to go to the next unprotected cell. By pressing Shift-Tab, you can g to the previous unprotected cell. Extra sheets for pages 6, 8 and 12 have been included in the file. Click Format-Sheet-Unhide to see the sheets available. Also there are some blank unprotected sheets after "Page 23".

If you have any questions concerning the diskette, please call Randy Hulskotter at (217) 782-1630.

RH/cw